Filing at a Glance

Company:	American General Life and Accident Insurance Company
Product Name:	AGLA1000-LDC-AR (0812) Application For Life and Disability Insurance, etal
State:	Arkansas
TOI:	ML02 Multi-Line - Other
Sub-TOI:	ML02.000 Multi-Line - Other
Filing Type:	Form
Date Submitted:	08/23/2012
SERFF Tr Num:	AGLA-128640850
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	AGLA1000-LDC-AR (0812), ETAL
Implementation Date Requested:	On Approval
Author(s):	Marilyn Ellis, Hyacinth Prince
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	08/23/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

General Information

Project Name: AGLA1000-LDC-AR (0812) Application For Life and Disability Insurance, etal

Status of Filing in Domicile: Pending

Project Number: AGLA1000-LDC-AR (0812)

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 08/23/2012

State Status Changed: 08/23/2012

Deemer Date:

Created By: Marilyn Ellis

Submitted By: Marilyn Ellis

Corresponding Filing Tracking Number:

Filing Description:

AGLA1000-LDC-AR (0812) Application For Life and Disability Insurance

AGLA1000-LDC-AR (0812) CR Conditional Receipt For Premium Deposit

AGLA2001-XQ REV0812 Medical Examiner's Report

The above forms are being submitted for your consideration and approval. AGLA1000-LDC-AR (0812) and AGLA1000-LDC-AR (0812) CR are new and do not replace any forms previously approved by your department. AGLA 2001-XQ REV0812 replaces AGLA2001-XQ REV0307, previously approved by your department on 5/16/07.

Form AGLA1000-LDC-AR (0812) is the application used if life insurance is applied for in combination with total disability insurance. Form AGLA1000-LDC-AR (0812) CR is the Conditional Receipt that will be used with AGLA1000-LDC-AR (0812).

AGLA2001-XQ REV0812 will be completed by the Medical Examiner for all life and health coverage when a medical examination is required. Only Part 1M will be made a part of the policy, but the entire form is being filed for approval.

If I may provide any additional information, please contact me.

Thank you.

Company and Contact

Filing Contact Information

Kathryn Mitchell,
American Gerneral Center
Nashville, TN 37250-0001

Kathryn.Mitchell@agla.com
615-749-1139 [Phone]

Filing Company Information

American General Life and Accident Insurance Company
American General Center
Nashville, TN 37250-0001
(615) 749-1139 ext. [Phone]

CoCode: 66672
Group Code: 12
Group Name: AIG
FEIN Number: 62-0306330

State of Domicile: Tennessee
Company Type: L&H
State ID Number:

State: *Arkansas* **Filing Company:** *American General Life and Accident Insurance Company*

TOI/Sub-TOI: *ML02 Multi-Line - Other/ML02.000 Multi-Line - Other*

Product Name: *AGLA1000-LDC-AR (0812) Application For Life and Disability Insurance, etal*

Project Name/Number: *AGLA1000-LDC-AR (0812) Application For Life and Disability Insurance, etal/AGLA1000-LDC-AR (0812)*

Filing Fees

Fee Required?	Yes
Fee Amount:	$150.00
Retaliatory?	No
Fee Explanation:	3 forms x $50 = $150.00
Per Company:	No

Company	Amount	Date Processed	Transaction #
American General Life and Accident Insurance Company	$150.00	08/23/2012	61938586

SERFF Tracking #:	*AGLA-128640850*	***State Tracking #:***		***Company Tracking #:***	*AGLA1000-LDC-AR (0812), ETAL*

State:	*Arkansas*	***Filing Company:***	*American General Life and Accident Insurance Company*
TOI/Sub-TOI:	*ML02 Multi-Line - Other/ML02.000 Multi-Line - Other*		
Product Name:	*AGLA1000-LDC-AR (0812) Application For Life and Disability Insurance, etal*		
Project Name/Number:	*AGLA1000-LDC-AR (0812) Application For Life and Disability Insurance, etal/AGLA1000-LDC-AR (0812)*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/23/2012	08/23/2012

SERFF Tracking #:	*AGLA-128640850*	***State Tracking #:***		***Company Tracking #:***	*AGLA1000-LDC-AR (0812), ETAL*

State:	*Arkansas*	***Filing Company:***	*American General Life and Accident Insurance Company*
TOI/Sub-TOI:	*ML02 Multi-Line - Other/ML02.000 Multi-Line - Other*		
Product Name:	*AGLA1000-LDC-AR (0812) Application For Life and Disability Insurance, etal*		
Project Name/Number:	*AGLA1000-LDC-AR (0812) Application For Life and Disability Insurance, etal/AGLA1000-LDC-AR (0812)*		

Disposition

Disposition Date: 08/23/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Name Change Endorsement	Approved-Closed	Yes
Supporting Document	Address Change Endorsement	Approved-Closed	Yes
Form	Application for Life and Disability Insurance	Approved-Closed	Yes
Form	Conditional Receipt For Premium Deposit	Approved-Closed	Yes
Form	Medical Examiner's Report	Approved-Closed	Yes

SERFF Tracking #:	*AGLA-128640850*	***State Tracking #:***		***Company Tracking #:***	*AGLA1000-LDC-AR (0812), ETAL*

State:	*Arkansas*	***Filing Company:***	*American General Life and Accident Insurance Company*
TOI/Sub-TOI:	*ML02 Multi-Line - Other/ML02.000 Multi-Line - Other*		
Product Name:	*AGLA1000-LDC-AR (0812) Application For Life and Disability Insurance, etal*		
Project Name/Number:	*AGLA1000-LDC-AR (0812) Application For Life and Disability Insurance, etal/AGLA1000-LDC-AR (0812)*		

Form Schedule

Lead Form Number: AGLA1000-LDC (0812)

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 08/23/2012	AGLA1000-LDC-AR (0812)	AEF	Application for Life and Disability Insurance	Initial:	52.600	1000-LDC-AR JD.pdf
2	Approved-Closed 08/23/2012	AGLA1000-LDC-AR (0812) CR	AEF	Conditional Receipt For Premium Deposit	Initial:	0.000	AGLA1000-LDC-AR (0812) CR.pdf
3	Approved-Closed 08/23/2012	AGLA2001-XQ REV0812	AEF	Medical Examiner's Report	Initial:	50.600	2001-XQ AR JD.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

APPLICATION FOR LIFE AND DISABILITY INSURANCE

American General Life and Accident Insurance Company
American General Center • Nashville, Tennessee 37250-0001

1. a. Primary Proposed Insured Name (Print full name) John Doe

b. Address 123 4th Street (Street) | Little Rock (City) | AR (State) | 72203 (Zip Code) | USA (Country)

c. SSN: 012-45-6789 | Birth Date and Place: Month 01 | Day 01 | Year 1977 | State AR | Country US | Age 35 | Gender [X] Male [ ] Female

d. Marital/Domestic Status: [ ] Single [X] Married [ ] Widowed [ ] Divorced [ ] Other

e. Driver's License No. 12345678 f. State of Issue AR

If over age 16 and no license, please explain.

g. Occupation Mechanic h. How long in occupation 10 Years

i. Employer ABC Repair j. Employer Address 567 8th Street

k. Job duties repairing cars l. Length of time employed by current employer 10 years

m. Average No. of hours worked per week in occupation 40

n. Is Primary Proposed Insured actively at work and able to perform all regular job duties? [X] Yes [ ] No

If "No," explain:

o. If no earned income, provide details of prior employment and job duties

p. If unemployed, retired prior to age 55, disabled or receiving Supplemental Security Income (SSI), provide explanation

q. Do you have any other full- or part-time job? [ ] Yes [X] No

If "Yes," provide occupation, job duties, hours worked and travel required.

r. Have you had any periods of unemployment? [ ] Yes [X] No

If "Yes," provide details.

s. Do you have any plans to change jobs in the next 6 months? [ ] Yes [X] No If "Yes," provide details.

t. Are you aware of any fact(s) that could change your occupation status or financial status? [ ] Yes [X] No

u. Are you a business owner? [ ] Yes [X] No If "Yes," what is your percentage of ownership?

v. Annual Earned Income (wages, commissions, bonus, profit sharing, or incentive payments) $ 55,000

w. Unearned Income (dividends and interest, rental income before depreciation, other) $ 0 Identify source.

2. a. Additional Proposed Insured Name (If coverage applied for)

b. Address (Street | City | State | Zip Code | Country)

c. SSN: | Birth Date and Place: Month | Day | Year | State | Country | Age | Gender [ ] Male [ ] Female

d. Marital/Domestic Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Other

e. Driver's License No. f. State of Issue

If over age 16 and no license, please explain.

g. Occupation h. How long in occupation

i. Employer j. Employer Address

k. Job duties l. Length of time employed by current employer

m. Average No. of hours worked per week in occupation

n. Is Additional Proposed Insured actively at work and able to perform all regular job duties? [ ] Yes [ ] No

If "No," explain:

o. If no earned income, provide details of prior employment and job duties

p. If unemployed, retired prior to age 55, disabled or receiving Supplemental Security Income (SSI), provide explanation

q. Do you have any other full- or part-time job? [ ] Yes [ ] No

If "Yes," provide occupation, job duties, hours worked and travel required.

r. Have you had any periods of unemployment? [ ] Yes [ ] No

If "Yes," provide details.

s. Do you have any plans to change jobs in the next 6 months? [ ] Yes [ ] No If "Yes," provide details.

t. Are you aware of any fact(s) that could change your occupation status or financial status? [ ] Yes [ ] No

u. Are you a business owner? [ ] Yes [ ] No If "Yes," what is your percentage of ownership?

v. Annual Earned Income (wages, commissions, bonus, profit sharing, or incentive payments) $

w. Unearned Income (dividends and interest, rental income before depreciation, other) $ Identify source.

Primary Proposed Insured _____

3. Enter names of children, stepchildren and legally adopted children for whom application for life insurance coverage under a Child Term Rider is made who are: (1) members of your immediate family and household; and (2) under the age of 18.

Full Name	Age	Birth Date Month	Day	Year	Gender	Relationship (If stepchild, consent required)
a.						
b.						
c.						
d.						

4. Owner Name (If other than Primary Proposed Insured) _____
Address _____
Street City State Zip Code
SSN/TIN: _____ Relationship to Primary Proposed Insured _____

5. Premium Payor Name (If other than Primary Proposed Insured) _____
Address _____
Street City State Zip Code
SSN/TIN: _____ Relationship to Primary Proposed Insured _____

6. Complete for Primary Proposed Insured:

a. Life Plan Name *Whole Life* If Term: Duration _____ Ins Amount $ *100,000*
If Universal Life: Death Benefit ☐ Option A ☐ Option B
For Indexed UL Only: Initial Premium Allocation Percentages
(Must Total 100%) Index Cap Account _____% Participation Rate Account _____ % Declared Interest Account _____%

b. Benefits & Riders

☐ Waiver Rider
☐ Additional Insurance Option $ _____
☐ Accidental Death $ _____
☐ Single Premium Whole Life $ _____
☐ Spouse Level Term Rider $ _____ Amt
☐ Accelerated Benefit Rider 2 Initial Defined Benefit – Primary Proposed Insured
☐ Accelerated Benefit Rider 2 Initial Defined Benefit – Additional Proposed Insured
☐ Primary Proposed Insured
  ☐ Disability Income Rider 2
  ☐ Disability Income Rider 5
  Monthly Benefit _____
  Occ. Class _____
☐ Other _____

☐ Terminal Illness Rider
☐ Monthly Guarantee Premium Rider
☐ Children's Term Rider $ _____ Amt
☐ Level Term Rider $ _____ Amt
☐ Additional Insured Rider $ _____ Amt
☐ 5% ☐ 10% ☐ Other _____
☐ 5% ☐ 10% ☐ Other _____
☐ Additional Proposed Insured
  ☐ Disability Income Rider 2
  ☐ Disability Income Rider 5
  Monthly Benefit _____
  Occ. Class _____
☐ Other _____

Home Office Use Only

Primary Proposed Insured _____

7. First Beneficiary(ies) *Jane Doe* | *Wife* | *33* | *987-65-1234* | *100*
   Name | Relationship | Age | SSN/TIN | Percentage

   _____
   Address

   _____
   Name | Relationship | Age | SSN/TIN | Percentage

   _____
   Address

   Secondary Beneficiary(ies) _____
   Name | Relationship | Age | SSN/TIN | Percentage

   _____
   Address

   _____
   Name | Relationship | Age | SSN/TIN | Percentage

   _____
   Address

8. Premium and Payment

   a. Premium $ *67.33* Lump Sum _____ ☐ 1035 exchange

   b. Payment Mode: ☐ A ☐ S ☐ Q ☒ M Planned Periodic Premium _____

   ☐ Other _____

   ☐ Automatic Bank Check
   ☐ AG Payroll Deduction (AGLA employees only)
   ☐ Payroll Deduction

   ☐ Add to existing ABC account, policy no. _____
   ☐ New payroll account no. _____
   ☐ Add to existing PD account no. _____
   Anticipated Effective Date of Coverage _____

   If premium mode is payroll deduction, are premiums to be paid with pre-tax dollars under a Section 125 (cafeteria plan sponsored by your employer)?
   ☐ Yes ☐ No

   c. If Available, is Automatic Premium Loan Provision to be in effect? ☐ Yes ☐ No

Primary Proposed Insured _____

If one or more additional policies are being applied for at this time having the SAME Owner and Premium Mode/Method, please complete the section(s) below:

9. a. Individual to be insured is the [X] Primary Proposed Insured or [ ] Additional Proposed Insured listed on this application.

b. Life Plan Name _____ If Term: Duration _____ Ins Amount $ _____ If UL: Death Benefit [ ] Option A [ ] Option B

c. Benefits & Riders

[ ] Waiver Rider

[ ] Accelerated Benefit Rider 2 Initial Defined Benefit for individual in 9.a. [ ] 5% [ ] 10% [ ] Other _____

[ ] Other _____ [ ] Other _____

d. Disability Plan: [X] On- & Off-the-Job Accident & Sickness Total Disability [ ] Other _____

Benefit Amount $5,000 Elimination Period [ ] 30 Days [X] 60 Days [ ] 180 Days

Riders [ ] Accidental Death & Dismemberment Rider _____ Units (1-6 units at $20,000 per unit)

[ ] Other _____ [ ] Other _____

e. If beneficiary is to be other than as listed in question 7, please complete the following:

First Beneficiary(ies) _____

Name Relationship Age SSN/TIN Percentage

_____

Address

_____

Name Relationship Age SSN/TIN Percentage

_____

Address

Secondary Beneficiary(ies) _____

Name Relationship Age SSN/TIN Percentage

_____

Address

_____

Name Relationship Age SSN/TIN Percentage

_____

Address

f. Premium $ 7.07 [ ] Lump Sum _____ [ ] 1035 exchange [ ] Planned Periodic Premium _____

Primary Proposed Insured _____

10. a. Individual to be insured is the ☐ Primary Proposed Insured or ☐ Additional Proposed Insured listed on this application.

b. Life Plan Name _____ If Term: Duration _____ Ins Amount $ _____ If UL: Death Benefit ☐ Option A ☐ Option B

c. Benefits & Riders

☐ Waiver Rider

☐ Accelerated Benefit Rider 2 Initial Defined Benefit for individual in 10.a. ☐ 5% ☐ 10% ☐ Other _____

☐ Other _____ ☐ Other _____

d. Disability Plan: ☐ On- & Off-the-Job Accident & Sickness Total Disability ☐ Other _____

Benefit Amount _____ Elimination Period ☐ 30 Days ☐ 60 Days ☐ 180 Days

Riders ☐ Accidental Death & Dismemberment Rider _____ Units (1-6 units at $20,000 per unit)

☐ Other _____ ☐ Other _____

e. If beneficiary is to be other than as listed in question 7, please complete the following:

First Beneficiary(ies) _____

Name Relationship Age SSN/TIN Percentage

_____

Address

_____

Name Relationship Age SSN/TIN Percentage

_____

Address

Secondary Beneficiary(ies) _____

Name Relationship Age SSN/TIN Percentage

_____

Address

_____

Name Relationship Age SSN/TIN Percentage

_____

Address

f. Premium $ _____ ☐ Lump Sum _____ ☐ 1035 exchange ☐ Planned Periodic Premium _____

Primary Proposed Insured _____

11. a. Individual to be insured is the ☐ Primary Proposed Insured or ☐ Additional Proposed Insured listed on this application.

b. Life Plan Name _____ If Term: Duration _____ Ins Amount $ _____ If UL: Death Benefit ☐ Option A ☐ Option B

c. Benefits & Riders

☐ Waiver Rider

☐ Accelerated Benefit Rider 2 Initial Defined Benefit for individual in 11.a. ☐ 5% ☐ 10% ☐ Other _____

☐ Other _____ ☐ Other _____

d. Disability Plan: ☐ On- & Off-the-Job Accident & Sickness Total Disability ☐ Other _____

Benefit Amount _____ Elimination Period ☐ 30 Days ☐ 60 Days ☐ 180 Days

Riders ☐ Accidental Death & Dismemberment Rider _____ Units (1-6 units at $20,000 per unit)

☐ Other _____ ☐ Other _____

e. If beneficiary is to be other than as listed in question 7, please complete the following:

First Beneficiary(ies) _____

Name Relationship Age SSN/TIN Percentage

_____

Address

_____

Name Relationship Age SSN/TIN Percentage

_____

Address

Secondary Beneficiary(ies) _____

Name Relationship Age SSN/TIN Percentage

_____

Address

_____

Name Relationship Age SSN/TIN Percentage

_____

Address

f. Premium $ _____ ☐ Lump Sum _____ ☐ 1035 exchange ☐ Planned Periodic Premium _____

Primary Proposed Insured _____

12. a. Individual to be insured is the ☐ Primary Proposed Insured or ☐ Additional Proposed Insured listed on this application.

b. Life Plan Name _____ If Term: Duration _____ Ins Amount $ _____ If UL: Death Benefit ☐ Option A ☐ Option B

c. Benefits & Riders

☐ Waiver Rider

☐ Accelerated Benefit Rider 2 Initial Defined Benefit for individual in 12.a. ☐ 5% ☐ 10% ☐ Other _____

☐ Other _____ ☐ Other _____

d. Disability Plan: ☐ On- & Off-the-Job Accident & Sickness Total Disability ☐ Other _____

Benefit Amount _____ Elimination Period ☐ 30 Days ☐ 60 Days ☐ 180 Days

Riders ☐ Accidental Death & Dismemberment Rider _____ Units (1-6 units at $20,000 per unit)

☐ Other _____ ☐ Other _____

e. If beneficiary is to be other than as listed in question 7, please complete the following:

First Beneficiary(ies) _____

Name Relationship Age SSN/TIN Percentage

_____

Address

_____

Name Relationship Age SSN/TIN Percentage

_____

Address

Secondary Beneficiary(ies) _____

Name Relationship Age SSN/TIN Percentage

_____

Address

_____

Name Relationship Age SSN/TIN Percentage

_____

Address

f. Premium $ _____ ☐ Lump Sum _____ ☐ 1035 exchange ☐ Planned Periodic Premium _____

Primary Proposed Insured_____

BACKGROUND/HEALTH QUESTIONS **YES** **NO**

13. Does any proposed insured have any of the coverages listed below inforce or have any pending application for such coverage with this Company or any other company? Check all applicable boxes. ..... ☐ ☒
If "Yes,"

Name Co. Name Amt. of Coverage/Benefit Pol. No.
☐ Life ☐ Health ☐ Long-term Care ☐ Disability/Period _____ ☐ Annuity

Name Co. Name Amt. of Coverage/Benefit Pol. No.
☐ Life ☐ Health ☐ Long-term Care ☐ Disability/Period _____ ☐ Annuity

Name Co. Name Amt. of Coverage/Benefit Pol. No.
☐ Life ☐ Health ☐ Long-term Care ☐ Disability/Period _____ ☐ Annuity

14. Will any existing insurance coverage or annuity contract be replaced or changed if any policy applied for is issued?..... ☐ ☒
If "Yes," complete the necessary replacement forms and provide details below.

Name Co. Name Type of Coverage Amt. of Coverage/Benefit Pol. No.

Name Co. Name Type of Coverage Amt. of Coverage/Benefit Pol. No.

Name Co. Name Type of Coverage Amt. of Coverage/Benefit Pol. No.

15. Within the past 5 years, has any proposed insured used tobacco (cigarettes, cigars, pipe, snuff, chewing tobacco) or nicotine patches, nicotine gum or any other form of nicotine? If "Yes," provide details below ..... ☐ ☒

Name Type Date of Last Use Frequency/Amount

Name Type Date of Last Use Frequency/Amount

16. Has any proposed insured ever had an application for insurance modified, rated, declined, postponed, or withdrawn? ..... ☐ ☒
If "Yes," provide details below.

Name Type of Coverage Date Details

Name Type of Coverage Date Details

17. Within the past 5 years, has any proposed insured been convicted of, paid a fine/ticket or pled guilty to reckless driving, driving while intoxicated, or had a driver's license revoked or suspended, or, within the past 3 years, had any moving traffic violations?..... ☐ ☒
If "Yes,"

Name Type of Violation Duration (if applicable) Date of Incident State of Incident

Details

Name Type of Violation Duration (if applicable) Date of Incident State of Incident

Details

Primary Proposed Insured _____

	YES	NO
18. Has any proposed insured ever been convicted of, pled guilty to, or pled no contest to a felony, or is any such charge pending against him/her? ..... If "Yes,"	☐	☒

Name _____ Date of Occurrence _____ County and State _____ Disposition _____

Details _____

Name _____ Date of Occurrence _____ County and State _____ Disposition _____

Details _____

19. Does any proposed insured intend to travel or reside outside of the United States within the next year? ..... If "Yes,"	☐	☒

Name(s) _____ City/Country where traveling _____ Length of Stay _____ Times Per Year _____

Purpose of Travel _____ Do you plan to visit non-urban areas _____ Trips outside of U.S. in prior two years _____

Name(s) _____ City/Country where traveling _____ Length of Stay _____ Times Per Year _____

Purpose of Travel _____ Do you plan to visit non-urban areas _____ Trips outside of U.S. in prior two years _____

20. Is any proposed insured **NOT** a citizen of the United States? ..... If "Yes,"	☐	☒

Name of proposed insured _____
Date of entry into the U.S. _____
Name of country of citizenship _____
Have Permanent Resident Card? ☐ Yes ☐ No
If "Yes," Provide A # _____
If No, does the proposed insured have a Visa? ☐ Yes ☐ No
If "Yes," Type of Visa: _____ (provide copy)
Intentions after expiration of Visa _____
Does the proposed insured own a home in the U.S.? ☐ Yes ☐ No
Are any family members U.S. Citizens or Permanent Residents? ☐ Yes ☐ No
If "Yes," give details _____
If no Permanent Resident Card and no Visa, please explain:

Name of proposed insured _____
Date of entry into the U.S. _____
Name of country of citizenship _____
Have Permanent Resident Card? ☐ Yes ☐ No
If "Yes," Provide A # _____
If No, does the proposed insured have a Visa? ☐ Yes ☐ No
If "Yes," Type of Visa: _____ (provide copy)
Intentions after expiration of Visa _____
Does the proposed insured own a home in the U.S.? ☐ Yes ☐ No
Are any family members U.S. Citizens or Permanent Residents? ☐ Yes ☐ No
If "Yes," give details _____
If no Permanent Resident Card and no Visa, please explain:

21. Within the past 5 years, has any proposed insured flown as a pilot, student pilot or crew member of any aircraft, or does any proposed insured have any intention to do so in the next 2 years?	☐	☒

If "Yes," Name _____ Details _____
Name _____ Details _____
If "Yes," submit an Aviation Questionnaire.

22. Within the past 5 years, has any proposed insured engaged in motor sports events or racing (auto, truck, cycle, boat, etc.); rock or mountain climbing; skin or scuba diving; aeronautics (hang-gliding, sky diving, parachuting, ultra light, soaring, ballooning)?	☐	☒

If "Yes," Name _____ Details _____
Name _____ Details _____
If "Yes," submit an Avocation Questionnaire.

Primary Proposed Insured _____

AGENT USE ONLY	YES	NO
MEDICAL EXAMINATION WILL BE SCHEDULED FOR: Primary Proposed Insured	☐	☒
Additional Proposed Insured	☐	☐

For any person who will be scheduled for a medical examination, please complete Questions 23. a. and 23. b.

23. a. Within the past 5 years, has any proposed insured been diagnosed as having or been treated for alcoholism, cancer or malignancy, HIV, heart attack, angina, kidney failure, Type 1 diabetes, emphysema, organ transplant or stroke, or been advised to have any diagnostic test or surgery not yet performed? ☐ ☐

If "Yes," name(s) of proposed insured(s) _____

b. Is any proposed insured age 71 or older? ☐ ☐

If "Yes," name(s) of proposed insured(s) _____

If "Yes" to 23. a. or 23. b., **no premium may be collected with this application.**

Questions 24 through 40 are only for persons proposed for insurance who are NOT expected to be subject to a Medical Examination. All applicants may, nevertheless, be subject to a Medical Examination at the Company's option.

Please complete questions 24-40 for each person who did not check "Yes" above, and for each child who is not an additional proposed insured:

24. a. Primary Proposed Insured: Height 6'0" Weight 190 lbs b. Additional Proposed Insured: Height _____ Weight _____

c. Has any proposed insured had a change in weight of 10 or more pounds in the past year? ☐ ☒

If "Yes," Name _____ Details _____

If "Yes," Name _____ Details _____

25. Is any proposed insured currently taking any medication or under medical observation, treatment, or therapy? ☐ ☒

If "Yes," Name _____

Give details including reasons for medication, treatment or therapy and name, address and telephone number of physician.

_____

_____

If "Yes," Name _____

Give details including reasons for medication, treatment or therapy and name, address and telephone number of physician.

_____

_____

26. Within the past 5 years, has any proposed insured consulted a doctor or been a patient in a hospital, clinic or treatment facility, or gone to a hospital emergency room or walk-in or similar clinic for medical care or consultation? ☐ ☒

If "Yes," Name _____

Date(s) _____ Duration _____ Type of Visit/Stay _____
(hospital, clinic, treatment facility, ER, walk-in or clinic)

Name, Address, and Telephone Number of the doctor, hospital, clinic, ER or treatment facility _____

_____

Give details _____

Name _____

Date(s) _____ Duration _____ Type of Visit/Stay _____
(hospital, clinic, treatment facility, ER, walk-in or clinic)

Name, Address, and Telephone Number of the doctor, hospital, clinic, ER or treatment facility _____

_____

Give details _____

27. In the immediate family of any proposed insured, has anyone been diagnosed or treated by a member of the medical profession for high blood pressure, heart disease prior to age 60, kidney disease, stroke, diabetes prior to age 55, sickle cell anemia, cerebrovascular disorder, aneurysm, or cancer? ☐ ☒

If "Yes," Name of Proposed Insured: _____

Relationship to Proposed Insured _____ Type/Details _____

Name of Proposed Insured: _____

Relationship to Proposed Insured _____ Type/Details _____

Primary Proposed Insured _____

	YES	NO
28. Has any proposed insured ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for high blood pressure?	☐	☒

If "Yes," Name _____
Date of diagnosis _____
Treatment _____
Last blood pressure reading and date _____
Highest blood pressure reading in past 12 months _____
Average blood pressure reading _____
Name and address of physician treating high blood pressure.

If "Yes," Name _____
Date of diagnosis _____
Treatment _____
Last blood pressure reading and date _____
Highest blood pressure reading in past 12 months _____
Average blood pressure reading _____
Name and address of physician treating high blood pressure.

	YES	NO
29. Has any proposed insured ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for diabetes?	☐	☒

If "Yes," Name _____
Date of diagnosis _____
Describe treatment _____
List any disability related to diabetes _____
Last blood sugar or HA1C reading and date _____
Has the proposed insured experienced diabetic coma, or vascular, kidney, heart, eye or other problems related to diabetes? ☐ Yes ☐ No
If "Yes," provide details _____
Name and address of physician treating diabetes _____

If "Yes," Name _____
Date of diagnosis _____
Describe treatment _____
List any disability related to diabetes _____
Last blood sugar or HA1C reading and date _____
Has the proposed insured experienced diabetic coma, or vascular, kidney, heart, eye or other problems related to diabetes? ☐ Yes ☐ No
If "Yes," provide details _____
Name and address of physician treating diabetes

	YES	NO
30. Within the past 5 years, has any proposed insured consumed alcoholic beverages?	☐	☒

If "Yes," Name _____ Average No. of drinks per week _____
Maximum No. of drinks per day _____ Type (Beer, Wine, Liquor) and Date of last use _____
Name _____ Average No. of drinks per week _____
Maximum No. of drinks per day _____ Type (Beer, Wine, Liquor) and Date of last use _____

	YES	NO
31. Has any proposed insured ever received medical treatment or counseling from a physician for, or been advised by a physician to discontinue or reduce, the use of alcohol or prescribed or non-prescribed drugs (cocaine, marijuana, heroin, methamphetamine) or other controlled substances, or has any proposed insured used such a non-prescribed drug or controlled substance, or any prescription medication other than as prescribed by a physician?	☐	☒

If "Yes," Name _____ Date(s) _____ Duration _____ Type _____
Details (including name, address and telephone number of the doctor, hospital, clinic or treatment facility) _____

Name _____ Date(s) _____ Duration _____ Type _____
Details (including name, address and telephone number of the doctor, hospital, clinic or treatment facility) _____

Primary Proposed Insured _____

	YES	NO
32. Within the past 10 years, has any proposed insured been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), or tested positive for the Human Immunodeficiency Virus (HIV)?	☐	☒
If "Yes," Name _____ Details _____		
Name and Address of Physician _____		
If "Yes," Name _____ Details _____		
Name and Address of Physician _____		
33. Within the past 12 months, has any proposed insured had one or more sores that have not healed, had changes in the appearance of a mole, experienced bleeding, chest pain, convulsions, dizziness, fatigue, hoarseness, numbness, or paralysis for which the cause is not known and for which a doctor has not been consulted?	☐	☒
If "Yes," Name _____ Date(s) _____ Duration _____ Type _____		
Details _____		
Name _____ Date(s) _____ Duration _____ Type _____		
Details _____		
34. In the past 24 months, has any proposed insured been advised by a member of the medical profession concerning any abnormal diagnostic test results, or been advised to have any diagnostic tests (including self-administered), treatment or surgery which was not completed or does any proposed insured have test results pending except those tests related to the Human Immunodeficiency Virus (AIDS virus)?	☐	☒
If "Yes," Name _____ Date(s) _____ Type _____		
Details _____		
(including name, address and telephone number of the doctor, hospital, clinic or treatment facility)		
Name _____ Date(s) _____ Type _____		
Details _____		
(including name, address and telephone number of the doctor, hospital, clinic or treatment facility)		
35. Does any proposed insured have a pending appointment with any physician or other medical professional or have the intent to make such appointment within the next 60 days?	☐	☒
If "Yes," Name _____ Date(s) _____ Type _____		
Details _____		
(including name, address and telephone number of the doctor, hospital, clinic or treatment facility)		
Name _____ Date(s) _____ Type _____		
Details _____		
(including name, address and telephone number of the doctor, hospital, clinic or treatment facility)		
36. Is any proposed insured currently a patient in or been advised to enter a hospital, nursing home, hospice or assisted living facility?	☐	☒
If "Yes," Name _____ Details _____		
Name _____ Details _____		
37. Has any proposed insured made claim for or received disability (other than for routine pregnancy) or Worker's Compensation benefits in the past 5 years?	☐	☒
If "Yes," Name _____ Type of Disability _____ Details _____		
Name _____ Type of Disability _____ Details _____		
38. Within the past 24 months, has any proposed insured:		
(a) been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for fainting, stumbling or falling while walking, problems with balance, deterioration in vision or hearing or shortness of breath?	☐	☒
(b) received home health care services, physical therapy or rehabilitation therapy?	☐	☒
(c) resided in senior citizen's housing or a retirement or assisted living community?	☐	☒
(d) required assistance or supervision with or had any limitations in performing, any of the following daily activities: bathing, bladder and/or bowel control, eating, dressing, toileting or transferring (moving into or out of a bed, chair or wheelchair)?	☐	☒
(e) required assistance with routine activities such as: using the phone, taking medications, paying bills, shopping, driving a car, traveling outside the home or preparing meals?	☐	☒

Primary Proposed Insured_____

	YES	NO
39. Has any proposed insured ever been diagnosed as having, or been treated for or consulted a licensed health care provider for any of the following: (If "Yes," check applicable boxes below.)		
(a) heart disease, heart attack, chest pain, shortness of breath, irregular heartbeat, heart murmur, high cholesterol or other disorder of the heart?	☐	☒
(b) a blood clot, aneurysm, stroke, transient ischemic attack, or other disease or disorder of the arteries or veins?	☐	☒
(c) cancer, malignant tumor or growth, leukemia, melanoma, Hodgkin's disease, non-Hodgkin's lymphoma, masses, cysts, polyps or other similar abnormalities?	☐	☒
(d) a disease or disorder of the thyroid or other glands or a disease or disorder of the immune or lymphatic system?	☐	☒
(e) a disease or disorder of the digestive system, throat, esophagus, stomach, intestine, liver, pancreas, or gall bladder?	☐	☒
(f) a disease or disorder of the urinary tract, kidneys, bladder, or prostate, or polycystic kidneys, or protein in the urine?	☐	☒
(g) a disease or disorder of the respiratory system, or asthma, chronic bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, sleep apnea, or other lung disorder?	☐	☒
(h) a disease or disorder of the nervous system, brain, or spinal cord, or cerebral palsy, multiple sclerosis, paralysis or seizures?	☐	☒
(i) anxiety, depression or other mental disorder?	☐	☒
(j) Alzheimer's disease or dementia?	☐	☒
(k) glaucoma, macular degeneration, optic neuritis?	☐	☒
(l) a disease or disorder of the blood, or anemia, hemophilia, sickle cell anemia?	☐	☒
(m) a disease or disorder of the muscles or bones, including but not limited to the back or joints?	☐	☒
(n) a disease or disorder of the reproductive system?	☐	☒
(o) severe headaches, stress, bipolar or nervous disorder?	☐	☒
(p) memory loss, unconsciousness, attention deficit disorder or loss of concentration?	☐	☒
(q) carpal tunnel syndrome or rheumatoid arthritis?	☐	☒
(r) a disease or disorder of the breast, disorder of menstruation, miscarriage, or complications of pregnancy?	☐	☒
(s) a disease or disorder of the skin, eyes, ears, sinuses or lymph glands?	☐	☒
(t) chronic fatigue syndrome, Epstein-Barr Virus, fibromyalgia, or Lyme Disease?	☐	☒
40. Has the proposed insured been advised to modify or restrict eating, drinking or living habits because of any health condition?	☐	☒

Explain "Yes" answers to questions 38-40.

Name	Date	Duration	Details	Name(s) and Address(es) of Doctor(s) or Hospital(s)

The space below may also be used to elaborate on any other question on this application.

OWNER'S CERTIFICATION

Under penalties of perjury, I certify that the following number, 012-45-6789 , is my correct taxpayer identification number, AND

Under penalties of perjury, I certify that I am not subject to backup withholding because:
(a) I am exempt from backup withholding, or
(b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest or dividends, or
(c) the IRS has notified me that I am no longer subject to backup withholding, AND

Under penalties of perjury, I certify that I am a U.S. person (including a U.S. resident alien).

You must cross out item (b) above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends in your tax return.

X John Doe — Signature of Owner — August 1, 2012 — Date

Consent to Insurance on Life of Minor Primary Proposed Insured

I hereby consent to the insurance plan, amount and beneficiary designation shown on the application and also reaffirm the answers to the health questions as they pertain to the Minor Primary Proposed Insured.

X _____ — Signature of Biological/Adoptive Father or Mother or of Legal Guardian — _____ — Date

X _____ — Signature of Biological/Adoptive Father or Mother or of Legal Guardian — _____ — Date

---

Consent to Children's Term Rider on Life of Minor Stepchild of Primary Proposed Insured or Additional Proposed Insured

I hereby consent to the insurance plan and amount shown on this application as to any biological and adopted child(ren) of mine listed in this application. I understand that the beneficiary of such applied-for coverage on such child(ren) will be the Owner of the policy. I affirm the answers to the health questions on this application as to such child(ren).

X _____ — Signature of Biological/Adoptive Father or Mother — _____ — Date

---

AGENT'S CERTIFICATION

I certify that I have asked each question and that the answers have been truly and accurately recorded as given. I have recorded any unfavorable information which I have knowledge of concerning any proposed insured. I confirm that any and all signatures of the Primary Proposed Insured, Additional Proposed Insured, Owner and Witness(es) in this application were signed in my presence.

August 1, 2012 — Date

Sally Shield — Signature of Licensed Agent

ACKNOWLEDGEMENT – AGREEMENT – AUTHORIZATION – UNDERSTAND – NOTICE

I, the Primary Proposed Insured (and any Owner or Additional Proposed Insured signing below), by my signature set forth hereafter:

Acknowledge that, if a Conditional Receipt was issued to me as a result of this application, I have read, or have been given the opportunity to read or to have read to me, all terms and provisions of such Conditional Receipt.

Agree that, under the Conditional Receipt, if any, given to me as the result of this application and under any additional pending application for other life, accident and/or health insurance coverage from American General Life and Accident Insurance Company ("the Company"), the aggregate liability on account of all coverages applied for with the Company will be the amount of coverage applied for or $250,000, whichever is less.

Agree that any temporary insurance arising under the terms of any Conditional Receipt given to me as a result of this application shall become effective only if and when such Conditional Receipt is delivered to the Owner.

Agree that all statements and answers in this application are complete and true to the best of my knowledge and belief and are the basis for any policy issued by the Company and agree that no information shall be deemed to have been given to the Company unless it is set forth in this application or in any supplemental application.

Agree that, except as stated in any Conditional Receipt, if such Conditional Receipt was given to me as a result of this application, the insurance will take effect on the Policy Date or Date of Issue, as the case may be, shown in the Policy if (a) the Policy has been delivered to me; (b) the first full modal premium for the Issued Policy has been paid while each proposed insured is alive; and (c) there has been no change in the health of any proposed insured that would change the answer to any question in this or any supplemental application before the conditions in items (a) and (b) above are met.

Agree that no agent of the Company or Medical Examiner has authority to waive any answer or otherwise modify this or any supplemental application or to bind the Company in any way by making any promise or representation which is not set out in writing in this application.

Authorize: (a) the Company to obtain an investigative consumer report on me; (b) any consumer reporting agency, employer, the Medical Information Bureau ("MIB"), and any governmental or other entity possessing non-health-related information concerning me to disclose such information to the Company, its reinsurers, and its legal representative. Any data obtained will be used by the Company to determine eligibility for insurance and will not be released by the Company to any person or organization, except to the Company's reinsurers, the MIB, other companies to whom I have applied or may apply for insurance coverage, other persons or organizations who perform business or legal services in connection with my application, and any entity to which release of such data is required by law. I know that I or my authorized representative may request to receive a copy of this Authorization. I agree that a facsimile of this Authorization shall be as valid as the original and that this Authorization shall be valid for the purpose of collecting information in connection with a claim for: (1) two and one-half years from the date shown below for the purpose of collecting information in connection with an application for insurance, (2) the term of coverage of the applied-for insurance policy, and (3) the duration of a claim for benefits.

ACKNOWLEDGE receipt of the following notices: (a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes; (b) MIB Pre-Notice; (c) Investigative Consumer Report; and (d) Outline of Coverage, if I have applied for a lump sum disability insurance policy.

UNDERSTAND that, if I am applying for a lump sum disability insurance policy such policy, if issued, will provide only lump sum disability insurance and will not be a major medical insurance policy.

NOTICE: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE: If a proposed insured's answers on this application are incorrect or untrue, the Company may have the right to deny benefits and/or rescind coverage.

PRIMARY PROPOSED INSURED - If an investigative consumer report is prepared in connection with this application:
☒ I elect to be interviewed. ☐ I elect NOT to be interviewed.

ADDITIONAL PROPOSED INSURED - If an investigative consumer report is prepared in connection with this application:
☒ I elect to be interviewed. ☐ I elect NOT to be interviewed.

AGENT - To the best of your knowledge, is the insurance applied for intended to replace any existing insurance? ☐ Yes (Explain) ☒ No

Signed at Little Rock (City) AR (State) August 1 (Date), 2012 X John Doe
SIGNATURE OF PRIMARY PROPOSED INSURED

X _____
SIGNATURE OF ADDITIONAL PROPOSED INSURED (IF APPLICABLE)

X _____
SIGNATURE OF OWNER (IF OTHER THAN PRIMARY PROPOSED INSURED)

X _____
SIGNATURE OF WITNESS (IF APPLICABLE)

X Sally Shield
SIGNATURE OF LICENSED AGENT

(NOT TO BE COMPLETED FOR PAYROLL DEDUCTION MODES)
CONDITIONAL RECEIPT FOR PREMIUM DEPOSIT
This Receipt is Valuable. Keep It in a Safe Place.

On this date, American General Life and Accident Insurance Company ("the Company") has received one of the following:
(Check the appropriate box and complete the statement beside it.)

☒ (1) $ 67.33 for life insurance and $ 7.07 for disability insurance applied for on John Doe (Name); or

☐ (2) a written authorization to initiate the debit entry to a checking/savings account with a financial institution in the amount of $_____ for life insurance and $_____ for disability insurance applied for on _____ (Name).

We agree to provide temporary insurance if (1) (a) the amount of any deposit shown above is equal to at least one-twelfth (1/12) of the annual premium for the policy applied for or (b) the amount of the debit entry to be initiated and deposited as shown above is equal to at least one-twelfth (1/12) of the annual premium for the policy applied for; and (2) all persons for whom application is made are insurable in the opinion of the Company's authorized underwriters in Nashville, Tennessee for the plan, insurance amount, and premium applied for on the date of the premium deposit or the written authorization to initiate the debit entry, as the case may be, and on the date of any required medical examination.

ANY TEMPORARY INSURANCE UNDER THIS CONDITIONAL RECEIPT IS SUBJECT TO THE AMOUNT AND TERMS OF THE POLICY APPLIED FOR EXCEPT THAT THE AGGREGATE LIABILITY FOR TEMPORARY INSURANCE FOR EACH PROPOSED INSURED UNDER THE CONDITIONAL RECEIPT AND UNDER THE CONDITIONAL RECEIPT FOR ANY ADDITIONAL, PENDING APPLICATION FOR OTHER LIFE, ACCIDENT AND/ OR HEALTH INSURANCE COVERAGE FROM THE COMPANY WILL BE THE AMOUNT OF COVERAGE APPLIED FOR OR $250,000, WHICHEVER IS LESS. IF TEMPORARY INSURANCE EXISTS UNDER THIS CONDITIONAL RECEIPT, IT WILL END UPON DELIVERY OF A POLICY OR 60 DAYS AFTER THE DATE OF THIS RECEIPT IF EARLIER.

No agent has authority to change or waive the terms and conditions of this Receipt. This Receipt is not valid if its date differs from that in the application, or if any check tendered as a premium deposit shown above is not honored when presented for payment, or if a debit entry authorized for a premium deposit is return unpaid.

August 1 , 2012	123	4567	Sally Shield
Date	Local Office	Agency No.	Signature of Licensed Agent

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

AGLA1000-LDC-AR (0812) CR

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. American General Life and Accident Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

American General Life and Accident Insurance Company, or its reinsurer(s), may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

AGLA1000 MIB (1004)

NOTICE TO HOLDER OF CONDITIONAL RECEIPT

This Receipt is Valuable. Do Not Destroy or Lose.

We will refund the premium deposit if we:
(a) decline to issue insurance; or
(b) issue a policy other than as applied for and you do not accept it.

If you do not receive a policy within 60 days from the date of deposit, return this Receipt for refund to our Local Office or to our Home Office, American General Center, Nashville, TN 37250-0001.

AGLA1000-LDC-AR (0812) CR

NOTICE OF INFORMATION PRACTICES

American General Life and Accident Insurance Company wishes to notify you that in processing your application for insurance, a Consumer Investigative Report may be prepared as to the character, general reputation, personal characteristics and/or mode of living of any person to be insured. The information for this report will be obtained through personal interviews with your friends, neighbors and acquaintances.

You have the right to make a written request within a reasonable time period to receive additional information about the nature and scope of this investigation.

(Printed in compliance with Public Law 91-508 and certain privacy protection statutes)

AGLA1000 NIP (1004)

(NOT TO BE COMPLETED FOR PAYROLL DEDUCTION MODES)
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(Check the appropriate box and complete the statement beside it.)

☐ (1) $_____ for life insurance and $ _____ for disability insurance applied for on _____ ; or
Name

☐ (2) a written authorization to initiate the debit entry to a checking/savings account with a financial institution in the amount of $_____ for life insurance and $_____ for disability insurance applied for on _____ .
Name

We agree to provide temporary insurance if (1) (a) the amount of any deposit shown above is equal to at least one-twelfth (1/12) of the annual premium for the policy applied for or (b) the amount of the debit entry to be initiated and deposited as shown above is equal to at least one-twelfth (1/12) of the annual premium for the policy applied for; and (2) all persons for whom application is made are insurable in the opinion of the Company's authorized underwriters in Nashville, Tennessee for the plan, insurance amount, and premium applied for on the date of the premium deposit or the written authorization to initiate the debit entry, as the case may be, and on the date of any required medical examination.

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_____ , _____	_____	_____	_____
Date	Local Office	Agency No.	Signature of Licensed Agent

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AGLA1000-LDC-AR (0812) CR

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Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

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AGLA1000-LDC-AR (0812) CR

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You have the right to make a written request within a reasonable time period to receive additional information about the nature and scope of this investigation.

(Printed in compliance with Public Law 91-508 and certain privacy protection statutes)

AGLA1000 NIP (1004)

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August 1 , 2012	123	4567	Sally Shield
Date	Local Office	Agency No.	Signature of Licensed Agent

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AGLA1000-LDC-AR (0812) CR

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(b) issue a policy other than as applied for and you do not accept it.

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AGLA1000-LDC-AR (0812) CR

APPLICATION TO AMERICAN GENERAL LIFE AND ACCIDENT INSURANCE COMPANY **PART 1M**
(To Be Completed By The Medical Examiner)

Name of Proposed Insured *John Doe* Birth Date 01 (Month) 01 (Day) 1977 (Year) Age 35

1. Name, address and telephone number of the proposed insured's primary physician. (If no primary physician, provide the name, address and telephone number of physician last seen.)
   Dr. James Smith, 987 10th Street, Little Rock, AR 72203 777-8888
   Date, reason, findings and treatment at last visit _____
   Name and address of physician(s) and other licensed health care provider(s) treating conditions in questions 6-9.
   _____

		Yes	No
2.	Is the proposed insured currently taking any medication or under medical observation, treatment, or therapy? If "Yes," give details including reasons for medication, treatment or therapy and name, address and telephone number of physician. _____	☐	☒
3.	Has the proposed insured had a change in weight of 10 or more pounds in the past year?	☐	☒
4.	Within the past 5 years, has the proposed insured consulted a physician or other licensed health care provider or been a patient in a hospital, clinic or treatment facility or gone to a hospital emergency room, walk in clinic, or similar clinic for medical care or consultation?	☐	☐

5.

Family History:	Age If Living	Age at Death	Cause of Death	Details/Date of Any Heart Disease Diagnosis	Details/Date of Any Cancer Diagnosis
Father	65				
Mother	63				
Brothers					
Sisters					

6.	Has the proposed insured ever been diagnosed with, been treated for, tested positive for, or been given medical advice regarding high blood pressure by a physician or other licensed health care provider?	☐	☒
	If "Yes," Date of diagnosis _____ Describe Treatment _____		
	Last blood pressure reading and date _____ Highest blood pressure reading in past 12 months _____		
	Average blood pressure reading _____		
7.	Has the proposed insured ever been diagnosed with, been treated for, tested positive for, or been given medical advice regarding diabetes by a physician or other licensed health care provider?	☐	☒
	If "Yes," Date of diagnosis _____ Describe treatment _____		
	List any disability related to diabetes _____ Last blood sugar or HA1C reading and date _____		
	Has the proposed insured experienced diabetic coma or vascular, kidney, heart, eye or other problems related to diabetes?	☐	☐
8.	Has the proposed insured ever been diagnosed with or been treated for severe headaches, stress, nervous disorder, or mental disorder, including anxiety, depression or bipolar disorder, by a physician or other licensed health care provider?	☐	☒
	If "Yes," Diagnosis _____ Date of diagnosis _____		
	Describe treatment _____		
	What factors lead to the diagnosis? _____ List any disability related to the diagnosis _____		
	Has the proposed insured been hospitalized related to the diagnosis?	☐	☐
	If "Yes," provide date and details _____		
	How many attacks or occurrences in the past 12 months? _____ How often do symptoms occur? _____		
9.	Has the proposed insured ever been diagnosed with, been treated for, tested positive for, or been given medical advice concerning sleep apnea, asthma, chronic bronchitis, or chronic obstructive pulmonary disease (COPD) by a physician or other licensed health care provider?	☐	☒
	If "Yes," Diagnosis _____ Date of diagnosis _____		
	Describe treatment _____ Date of last treatment _____		
	Describe symptoms (when & how often do they occur?) _____		
	List any disability related to the diagnosis _____		
10.	Within the past 5 years, has the proposed insured used tobacco (cigarettes, cigars, pipe, snuff, chewing tobacco) or nicotine patches, nicotine gum,or any other form of nicotine?	☐	☒
	If "Yes," Type _____ Date of Last Use _____ Frequency/Amount _____		
11.	Within the past 5 years, has the proposed insured used alcoholic beverages?	☐	☒
	If "Yes," Average No. of drinks per week _____ Maximum No. of drinks per day _____		
	Type (Beer, Wine, Liquor) _____ Date of last use _____		

		Yes	No
12.	Has the proposed insured ever received medical treatment or counseling from a physician or other licensed health care provider for, or been advised by a physician or other licensed health care provider to discontinue or reduce, the use of alcohol or prescribed or non-prescribed drugs (cocaine, marijuana, heroin, methamphetamine) or other controlled substances, or has the proposed insured used such a non-prescribed drug or controlled substance or used any prescription medication other than as prescribed by a physician or other licensed health care provider?	☐	☒
	If "Yes," Type of drug(s)/alcohol product(s) _____ Date last used _____		
	Name(s) of doctor/facility_____ Phone (_____)_____		
	Address _____ City _____ Zip_____		
	Treatment Dates _____ Support Groups _____ Last Date attended_____		
	Details of any drug or alcohol related arrests _____		
13.	Within the past 10 years, has the proposed insured been diagnosed by a physician or other licensed health care provider as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus (HIV)?	☐	☒
14.	Within the past 12 months, has the proposed insured experienced any of the following: paralysis for which the cause is not known and for which a physician or other licensed health care provider has not been consulted, one or more sores that have not healed, changes in the appearance of a mole, bleeding, chest pain, convulsions, dizziness, fatigue, hoarseness, or numbness?	☐	☒
15.	In the past 24 months, has the proposed insured been advised by a physician or other licensed health care provider concerning any abnormal diagnostic test result(s) or been advised to have any diagnostic test(s) (including self-administered) or treatment or surgery which was not completed, or does the proposed insured have one or more test results pending (except those tests related to the Human Immunodeficiency Virus (AIDS virus))?	☐	☒
16.	Does the proposed insured have a pending appointment with any physician or other licensed health care provider or have the intent to make such an appointment within the next 60 days?	☐	☒
17.	Has the proposed insured been advised to enter a hospital, nursing home, hospice or assisted living facility?	☐	☒
18.	Has the proposed insured made claim for or received disability benefits (other than for routine pregnancy) or Worker's Compensation benefits in the past 5 years?	☐	☒
	If "Yes," Type of Disability _____ Details _____		
19.	Within the past 24 months, has the proposed insured:		
	(a) been diagnosed with, been treated for, tested positive for, or been given medical advice concerning fainting, stumbling or falling while walking, problems with balance, deterioration in vision or hearing or shortness of breath by a physician or other licensed health care provider?	☐	☒
	(b) received home health care services, physical therapy or rehabilitation therapy?	☐	☒
	(c) resided in senior citizen's housing or a retirement or assisted living community?	☐	☒
	(d) required assistance or supervision with or had any limitations in performing, any of the following daily activities: bathing, bladder and/or bowel control, eating, dressing, toileting or transferring (moving into or out of a bed, chair or wheelchair)?	☐	☒
	(e) required assistance with routine activities such as: using the phone, taking medications, paying bills, shopping, driving a car, traveling outside the home or preparing meals?	☐	☒
20.	Has the proposed insured ever been diagnosed with, been treated for, or consulted a physician or other licensed health care provider for any of the following: (If "Yes," check applicable boxes below.)		
	(a) heart disease, heart attack, chest pain, shortness of breath, irregular heartbeat, heart murmur, high cholesterol or other disorder of the heart?	☐	☒
	(b) a blood clot, aneurysm, stroke, transient ischemic attack, or other disease or disorder of the arteries or veins?	☐	☒
	(c) cancer, malignant tumor or growth, leukemia, melanoma, Hodgkin's disease, non-Hodgkin's lymphoma, masses, cysts, polyps or other similar abnormalities?	☐	☒
	(d) a disease or disorder of the thyroid or other glands or a disease or disorder of the immune or lymphatic system?	☐	☒
	(e) a disease or disorder of the digestive system, throat, esophagus, stomach, intestine, liver, pancreas, or gall bladder?	☐	☒
	(f) a disease or disorder of the urinary tract, kidneys, bladder, or prostate, or polycystic kidneys, or ever been diagnosed with protein in the urine?	☐	☒
	(g) a disease or disorder of the respiratory system, or emphysema, or other lung disorder?	☐	☒
	(h) a disease or disorder of the nervous system, brain, or spinal cord, or cerebral palsy, multiple sclerosis, paralysis or seizures?	☐	☒
	(i) Alzheimer's disease or dementia?	☐	☒
	(j) glaucoma, macular degeneration, or optic neuritis?	☐	☒
	(k) a disease or disorder of the blood, or anemia, hemophilia, or sickle cell anemia?	☐	☒
	(l) a disease or disorder of the muscles or bones, including but not limited to the back or joints?	☐	☒
	(m) a disease or disorder of the reproductive system?	☐	☒
	(n) memory loss, unconsciousness, attention deficit disorder, or loss of concentration?	☐	☒
	(o) carpal tunnel syndrome or rheumatoid arthritis?	☐	☒
	(p) a disease or disorder of the breast, disorder of menstruation, miscarriage, or complications of pregnancy?	☐	☒
	(q) a disease or disorder of the skin, eyes, ears, sinuses, or lymph glands?	☐	☒
	(r) chronic fatigue syndrome, Epstein-Barr Virus, fibromyalgia, or Lyme Disease?	☐	☒
21.	Has the proposed insured been advised to modify or restrict eating, drinking or living habits because of any health condition?	☐	☒

If answered "Yes" to questions 4, 13-21, provide appropriate details such as: diagnosis; date of diagnosis; name, address and telephone number of physician; tests performed; test results; medications or recommended treatment.

_____

_____

_____

_____

Continuation of PART 1M

I agree that all statements and answers in this application are complete and true to the best of my knowledge and belief. I agree that this application will become a part of the policy applied for and any policy will be issued on the basis of my answers and statements. I agree that no agent of the Company or the Medical Examiner has authority to waive any answer or otherwise modify this application or bind the Company in any way by making any promise or representation which is not set out in writing in this application. **Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

Dated at Little Rock, AR

this 1st day of August, 2012

Witnessed by Dr. James Smith
(Medical Examiner)

John Doe
Signature of Proposed Insured

Signature of Parent or Guardian required if Proposed Insured has not reached his sixteenth birthday.

American General Life and Accident Insurance Company

American General Center • Nashville, Tennessee 37250-0001

PART 2M

MEDICAL EXAMINER'S REPORT

22. a. Height (in shoes) ft. in.	Weight (Clothed) lbs.	Males Only: Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in

b. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

23. Blood Pressure (If pressure over 140/90 give additional readings)			
Systolic			
Diastolic 5th phase			

24. Pulse:	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

25. Heart: Is there any:

Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No

Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No

(describe below–if more than one, describe separately)

	Murmur #1	Murmur #2
Location		
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐
After exercise:		
Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

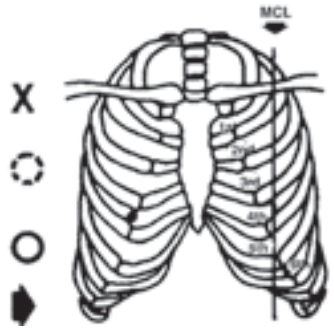
Indicate:

Apex by X

Murmur area by ◌

Point of greatest intensity by ○

Transmission by



For comments and your impression.

Details of "Yes" answers. (Identify item.)

Examiner's Observation and Remarks

	Yes	No
a. Does the applicant appear to be stated age? ..... If "No," explain _____	☐	☐
b. Are there any obvious physical abnormalities? ..... If "Yes," explain _____	☐	☐
c. Does applicant use any devices to aid in locomotion (i.e., cane, walker, wheelchair)? ..... If "Yes," explain _____	☐	☐
d. Does applicant seem alert, oriented to time and place? ..... If "No," explain _____	☐	☐
e. Does applicant have any speech difficulties? ..... If "Yes," explain _____	☐	☐

URINALYSIS ➤	Are you satisfied it is authentic? ☐ Yes ☐ No	Specific Gravity	Albumin (even a trace)	Sugar (even a trace)	Occult blood?	Are you mailing specimen to Home Office? (See Instructions below.) ☐ Yes ☐ No

NOTICE–FORWARD Specimen to Lab, if

a. Albumin or sugar is found, or there is any history or presence of hypertension (blood pressure exceeds 150/90), heart or genito-urinary disorder.

b. Amount of insurance (listed above) is **$100,000** or more through age 55; **$50,000** or more ages 56 and over.

c. Agent requests it when examination arranged.

I certify that the proposed insured was examined by me in private at ☐ my office ☐ applicant's home ☐ applicant's place of work

this_____ day of _____, _____ at _____ o'clock A.M. P.M.

Signature of Examiner _____ **Address** _____

This report should be returned to our Company address shown above.

State: Arkansas **Filing Company:** American General Life and Accident Insurance Company
TOI/Sub-TOI: ML02 Multi-Line - Other/ML02.000 Multi-Line - Other
Product Name: AGLA1000-LDC-AR (0812) Application For Life and Disability Insurance, etal
Project Name/Number: AGLA1000-LDC-AR (0812) Application For Life and Disability Insurance, etal/AGLA1000-LDC-AR (0812)

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Name Change Endorsement	Approved-Closed	08/23/2012
Bypass Reason:	Not applicable to this filing.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Address Change Endorsement	Approved-Closed	08/23/2012
Bypass Reason:	Not applicable to this filing.		
Comments:			